

BREAST REDUCTION CONSULTATION

Name \_\_\_\_\_

Date \_\_\_\_\_ Referring Physician \_\_\_\_\_

Indications/Symptoms \_\_\_\_\_

Neck pain \_\_\_ Y \_\_\_ N Upper back pain \_\_\_ Y \_\_\_ N Shoulder Grooving \_\_\_ Y \_\_\_ N

Head aches \_\_\_ Y \_\_\_ N Rashes \_\_\_ Y \_\_\_ N Bra Size \_\_\_\_\_

Smoke \_\_\_ Y \_\_\_ N

Allergies \_\_\_\_\_

Medications \_\_\_\_\_

Surgeries \_\_\_\_\_

Problems with Anesthesia or Bleeding \_\_\_\_\_

Keloid former \_\_\_\_\_

Pregnancies \_\_\_\_\_

Mammogram \_\_\_\_\_

Conservative Treatment \_\_\_ Y \_\_\_ N- if yes how long \_\_\_\_\_

Physical Therapy \_\_\_ Y \_\_\_ N- if yes how long \_\_\_\_\_

Chiropractic Treatment \_\_\_ Y \_\_\_ N- if yes how long \_\_\_\_\_

Massage Therapy \_\_\_ Y \_\_\_ N- if yes how long \_\_\_\_\_

Back exercise \_\_\_ Y \_\_\_ N- if yes how long \_\_\_\_\_

Non steroidal medication \_\_\_ Y \_\_\_ N- if yes how long \_\_\_\_\_

PHYSICIAN USE\*\*\*\*\*

Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ BMI \_\_\_\_\_

Approx grams to be removed Left \_\_\_\_\_ Right \_\_\_\_\_

Nipple to sternal notch Left \_\_\_\_\_ Right \_\_\_\_\_